just above the bladder and to the right of the body of the uterus. The mass adhered firmly to the uterus and extended to involve the posterior bladder wall as well. The bladder was opened and dissected free from the mass. Repair first required partial cystectomy. The fistula was repaired; total abdominal hysterectomy, left salpingo-oophorectomy and right salpingectomy were performed. The patient tolerated the procedure well, and her postoperative course was uneventful.

Where was the implantation site in this patient? Primary intra-uterine pregnancy was excluded: despite uterine enlargement, vaginal bleeding was always scant and no tissue was expelled per vaginam. The attempted abortion could hardly have ruptured the uterine wall, causing translocation of an endometrial implant; in fact, the abortifacient fluid apparently did not enter the uterus. Finally, histologic evidence of endometrial implantation was absent.

Tubal implantation was also excluded by histological examination. Follicular salpingitis (Fig. 1) may conceivably have caused prolonged ovum transport, thus contributing to implantation proximal to the endometrial cavity.

Clinical, operative and histological evidence points to rupture of an interstitial pregnancy (Figs. 2 and 3). Fetal bone and cartilage lay within a hematoma communicating with bladder; sections of cornual myometrium formed part of the wall of the hematoma and enclosed placental villi.

Rupture of the ectopic pregnancy apparently occurred at the time of the second hospital admission when the patient complained of severe abdominal pain and became febrile. It would appear that trophoblastic invasion subsequently penetrated the urinary bladder, resulting in fistulation and partial abortion of the disintegrating fetus via the urinary stream.

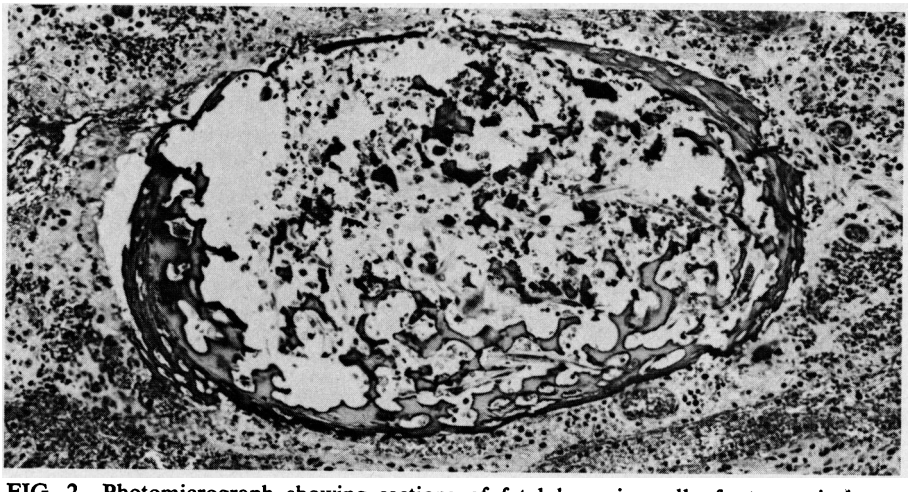

FIG. 2—Photomicrograph showing sections of fetal bone in wall of uterovesical fistula. Hematoxylin, phloxine and saffron. x 120.

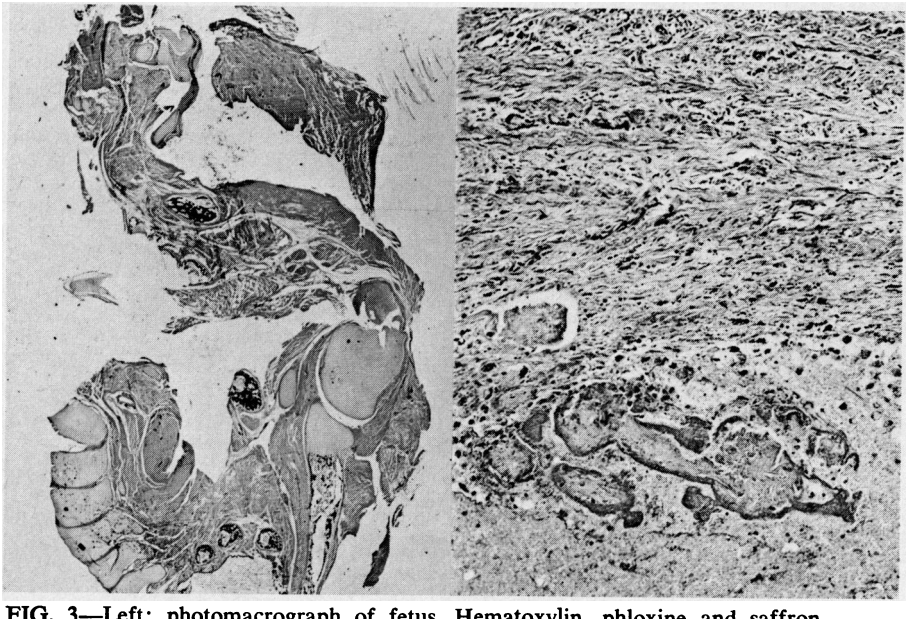

FIG. 3—Left: photomacrograph of fetus. Hematoxylin, phloxine and saffron. Reduced ¼ from x 9. Right: implantation site, with invasion of myometrium by primitive placental villi. Hematoxylin, phloxine and saffron. Reduced ¼ from x 120.

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"Why don't they take drugs"

To the Editor: I was astonished to read the following statement in Dr. S. S. B. Gilder's Overseas Report (*Can Med Assoc J* 109: 466, 1973): "Many were, in fact, too busy to bother with drugs. Some found all the solace they needed in tobacco or alcohol."

Such a statement adds to the difficulty of convincing the medical profession and the public that alcohol is a psychoactive drug. An excerpt from the Report of the Council on Community Health to General Council of the CMA in June of this year reads as follows: "It would seem appropriate at this time for the C.M.A. to reaffirm to the general public and to its own membership, *that alcohol is a psychoactive drug,* that it should be talked of as such in all programmes, and that it is by far the drug of widest misuse by our whole population, and in particular by our high school and other youth."

It is unfortunate that Dr. Gilder's informative article should contain a dichotomy; it is even more unfortunate that he is not alone in dismissing alcohol as a "non-drug" substance.

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